STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155412	A. BUILDING -- B. WING	05/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREENWOOD HEALTH AND LIVING COMMUNITY	937 FRY RD GREENWOOD, IN 46142

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 05/24/23 Facility Number: 000509 Provider Number: 155412 AIM Number: 100266620 At this Emergency Preparedness survey, Greenwood Health & Living Community was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 121 certified beds. At the time of the survey, the census was 89. Quality Review completed on 05/25/23	E 0000	June 8th, 2023 Brenda Buroker, Director Long-Term Care Division Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204 Re: Allegation of Compliance Dear Mrs. Buroker: Please find enclosed the Plan of Correction to the Life Safety Code Survey conducted on May 24, 2017. This letter is to inform you that the plan of correction attached is to serve as Greenwood Health and Living credible allegation of compliance. Submission of this plan of correction in no way constitutes an admission by Greenwood Health & Living or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care or other services provided in this facility. The Plan of Correction is prepared and executed solely because it is required by Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the Life Safety Code Survey on May 24th, 2023.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Daniel Kern	Administrator	06/08/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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			This statement of deficiencies and plan of correction will be reviewed at the Monthly Quality Assurance/Assessment Committee meeting. Please accept this plan of correction as Greenwood Health and Living's credible allegation of compliance by June 8, 2023. We are requesting a desk review for this plan of correction. If you have any further questions, please do not hesitate to contact me at 317-881-3535. Sincerely, Dan Kern, Administrator	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 05/24/23 Facility Number: 000509 Provider Number: 155412 AIM Number: 100266620 At this Life Safety Code survey, Greenwood Health And Living Community was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.	K 0000	June 8th, 2023 Brenda Buroker, Director Long-Term Care Division Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204 Re: Allegation of Compliance Dear Mrs. Buroker: Please find enclosed the Plan of Correction to the Life Safety Code Survey conducted on May 24, 2017. This letter is to inform you that the plan of correction attached is to serve as Greenwood Health and Living credible	

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	This one story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has battery operated smoke detectors installed in all resident sleeping rooms. The facility has a capacity of 121 and had a census of 89 at the time of this visit. All areas where residents have customary access were sprinklered. The facility has two detached buildings providing facility storage services which were not sprinklered. Quality Review completed on 05/25/23		allegation of compliance. Submission of this plan of correction in no way constitutes an admission by Greenwood Health & Living or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care or other services provided in this facility. The Plan of Correction is prepared and executed solely because it is required by Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the Life Safety Code Survey on May 24th, 2023. This statement of deficiencies and plan of correction will be reviewed at the Monthly Quality Assurance/Assessment Committee meeting. Please accept this plan of correction as Greenwood Health and Living's credible allegation of compliance by June 8, 2023. We are requesting a desk review for this plan of correction. If you have any further questions, please do not hesitate to contact me at 317-881-3535. Sincerely, Dan Kern, Administrator	
K 0291 SS=F Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour			

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	duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 Based on record review and interview, the facility failed to document annual testing for all battery backup lights in accordance with LSC 7.9. Section 7.9.3.1.1 states testing of emergency lighting systems shall be permitted to be conducted as follows: (1) Functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, except as otherwise permitted by 7.9.3.1.1(2). (2) The test interval shall be permitted to be extended beyond 30 days with the approval of the authority having jurisdiction. (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered. (4) The emergency lighting equipment shall be fully operational for the tests required by 7.9.3.1.1(1) and (3). (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of Direct Supply TELS Logbook "Emergency and Exit Lighting" documentation for the most recent twelve month period with the Maintenance Director during record review from 9:15 a.m. to 12:45 p.m. on 05/24/23, documentation of an itemized listing for the annual 90-minute test of all battery operated light locations in the facility for the most recent twelve month period was not available for review. Weekly generator testing	K 0291	**K-291-Emergency Lighting annual Testing** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Facility Emergency Lighting has been tested. See attachment. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. Residents have the potential to be affected. facility emergency lighting has been tested What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. TELS task has been added for emergency lighting to be tested annually. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. TELS task has been added for emergency lighting to be tested annually. By what date the systemic changes for each deficiency will be completed. 6/8/2023	06/08/2023

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	documentation for the most recent twelve month period documented 30 second functional testing for the battery operated light at the emergency generator location but did not document annual 90-minute testing for all battery light locations. Based on interview at the time of record review, the Maintenance Director stated the facility has a total of three battery operated lights, annual 90-minute testing was completed at the end of 2022 but agreed annual 90-minute testing documentation for battery operated light locations in the facility within the most recent twelve month period was not available for review at the time of the survey. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)			
K 0324 SS=D Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4.			

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	Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on record review and interview, the facility failed to ensure 1 of 1 kitchen range hood exhaust systems was maintained in proper working order. NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 2011 Edition, Section 7.8.2.1(8) requires rooftop terminations to be arranged with or provided with a hinged upblast fan supplied with flexible weatherproof electrical cable and service hold-open retainer to permit inspection and cleaning that is listed for commercial cooking equipment. This deficient practice could affect over two kitchen staff. Findings include: Based on review of the kitchen range hood system inspection contractor's "Courtesy After Service Report" inspection documentation dated 11/21/22 with the Maintenance Director during record review from 9:15 a.m. to 12:45 p.m. on 05/24/23, the range hood exhaust system fans needs a hinge kit. The "Service Results" section of the 11/21/22 report checked the results of the inspection as "Unsatisfactory" due to "needs hinge kit". Review of the kitchen range hood system inspection contractor's subsequent "Job Service Report" inspection documentation dated 03/03/23 did not state the status of needing a hinge kit. Based on interview at the time of record review, the Maintenance Director stated he was not aware of any recent hinge kit installation and stated hinge kit installation documentation on or after 11/21/22 was not available for review at the	K 0324	**K-324- Hinge kit on Hood in kitchen** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Kitchen hood system hinge kit was installed by Hoodz on 6/6/2023. See attachment. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; Residents in facility have the potential to be affected. Kitchen hood system hinge kit was installed by Hoodz on 6/6/2023. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Kitchen hood system will be cleaned semi-annually per TELS. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; Per TELS Preventive Maintenance system, the kitchen hood system will be checked with appropriate follow up to inspection as needed. By what date the systemic	06/08/2023

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	time of the survey. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		changes for each deficiency will be completed. 6/8/2023	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____________________ b) Who provided system test ____________________________ c) Water system supply source __________________________ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25			
	Based on record review and interview, the facility failed to maintain automatic sprinkler systems in accordance with NFPA 25. LSC 9.7.5 requires all sprinkler systems shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, Section 4.1.4.1 states the property owner or designated representative shall correct or repair deficiencies or impairments that are found during the inspection, test and maintenance required by	K 0353	**<u>K-353= PIV Valve</u>** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Safecare inspected the PIV on 6/5/2023. Safecare found wire under the ground to be compromised. Currently waiting on quote for replacement. See attachment.	06/08/2023

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	this standard. Corrections and repairs shall be performed by qualified maintenance personnel or a qualified contractor. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on review of the sprinkler system inspection contractor's "Annual Water-Based Fire Protection Systems Inspection" documentation dated 11/11/22 with the Maintenance Director during record review from 9:15 a.m. to 12:45 p.m. on 05/24/23, deficiencies were noted for the facility's Post Indicator Valve (PIV). The "Supervisory Devices" section of the 11/11/22 sprinkler system inspection report stated "Fail" in response to "Functional Test" of the "Tamper Switch" for the PIV. Review of the sprinkler system inspection contractor's "Quarterly Water-Based Fire Protection Systems Inspection" documentation dated 02/01/23 indicated the "Functional Test" for the "Tamper Switch" for the PIV was "Not Due". PIV tamper switch repair or replace documentation on or after 11/11/22 was not available for review. Based on interview at the time of record review, the Maintenance Director stated PIV tamper switch repair or replace documentation on or after 11/11/22 was not available for review. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; residents in facility have the potential to be affected. Safecare inspected the PIV on 6/5/2023 and found wire under ground to be compromised. Currently waiting on quote for replacement. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Sprinkler system will be inspected manually per TELS. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. Sprinkler system will be inspected manually per TELS. By what date the systemic changes for each deficiency will be completed. 6/8/23.	

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K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS.			
	Based on observation and interview, the facility failed to ensure 1 of 8 smoke barrier walls were protected to maintain the fire resistance rating of the smoke barrier wall. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. This deficient practice could affect over 15 residents, staff and visitors in the vicinity of the smoke barrier wall by Room 103. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:45 p.m. to 2:20 p.m. on 05/24/23, a six inch in diameter hole was noted in the attic smoke barrier wall above the corridor door set by Room 103. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned opening in the smoke barrier wall in the attic above the corridor door set by Room 103 was not firestopped to maintain the fire resistance rating of	K 0372	**K-372- Smoke barrier construction** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Hole in smoke barrier wall has been repaired. See attachment. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. Residents on 100 hallway have the potential to be affected.- Hole in smoke barrier wall has been repaired. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. Maintenance Supervisor will ensure that all fire barrier walls are	06/08/2023

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	the smoke barrier wall. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		maintained within the community. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. Per TELS task, Maintenance Director will monitor that all fire barrier walls are maintained within the community. By what date the systemic changes for each deficiency will be completed? 6/8/23	
K 0500 SS=F Bldg. 01	NFPA 101 Building Services - Other Building Services - Other List in the REMARKS section any LSC Section 18.5 and 19.5 Building Services requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on record review, observation and interview; the facility failed to ensure all fuel fired water heaters had current inspection certificates to ensure the water heaters were in safe operating condition. NFPA 101, Section 19.1.1.3.1 requires all health facilities to be designed constructed, maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice affects all residents, staff and visitors. Findings include: Based on record review with the Maintenance Director from 9:15 a.m. to 12:45 p.m. on 05/24/23, current inspection certificates from the State of	K 0500	**K-500 water heater inspection certificate** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Boiler inspections from insurance company have been completed. See attached permits. See attachment. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; Residents in facility have the potential to be	06/08/2023

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	Indiana for all fuel fired water heaters in the facility was not available for review. Based on observations with the Maintenance Director during a tour of the facility from 12:45 p.m. to 2:20 p.m. on 05/24/23, the following fuel fired heaters had missing Certificate of Inspection documentation from the State of Indiana: a. the fuel fired boiler identified as IN369979 in the Mechanical Room accessed from the outside of the facility by the emergency generator. b. the fuel fired boiler identified as IN369970 in the Mechanical Room accessed from the outside of the facility by the emergency generator. c. the service water heater identified as IN344437 in the Mechanical Room in the south Dining Room. Based on interview at the time of the observations, the Maintenance Director stated current Certificate of Inspection documentation should have been in the Life Safety Code book for the facility but agreed the aforementioned fuel fired heaters each had missing Certificate of Inspection documentation from the State of Indiana. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		affected. Boiler inspections from insurance company have been completed. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; A TELS work order has been created to ensure water heaters are inspected and certificates will be maintained. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; A TELS work order has been created to ensure water heaters are inspected and certificates will be maintained. By what date the systemic changes for each deficiency will be completed? 6/8/2023	
K 0521 SS=F Bldg. 01	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 Based on record review and interview, the facility	K 0521	**K-521- Fire Dampers**	06/08/2023

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	failed to ensure all fire dampers in the facility were inspected and provided necessary maintenance within the most recent four year period in accordance with NFPA 90A. LSC 9.2.1 requires heating, ventilating and air conditioning (HVAC) ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 2012 Edition, Section 5.4.8.1 states fire dampers shall be maintained in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. NFPA 80, 2010 Edition, Section 19.4.1 states each damper shall be tested and inspected 1 year after installation. The test and inspection frequency shall be every 4 years. If the damper is equipped with a fusible link, the link shall be removed for testing to ensure full closure and lock-in-place if so equipped. The damper shall not be blocked from closure in any way. All inspections and testing shall be documented, indicating the location of the fire damper, date of inspection, name of inspector and deficiencies discovered. The documentation shall have a space to indicate when and how the deficiencies were corrected. Section 19.4.3 states full unobstructed access to the fire damper shall be verified and corrected as required. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of the fire damper inspection contractor's "Fire/Smoke Damper Maintenance Record" inspection documentation dated 10/26/22 with the Maintenance Director during record review from 9:15 a.m. to 12:45 p.m. on 05/24/23, a total of 14 fire dampers were inspected and tested within the most recent four year period. Review of the fire damper inspection contractor's		What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Fire Dampers were reinspected by Complete Mechanical on 5/31/23. See attachment. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. Residents in facility have the potential to be affected. Fire Dampeners were inspected by Complete Mechanical. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. Fire dampers will be inspected per TELS task every four years. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. TELS task has been added for fire dampers to be inspected every four years. By what date the systemic changes for each deficiency will be completed? 6/8/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155412	A. BUILDING 01 B. WING	05/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	"Fire/Smoke Damper Maintenance Record" inspection documentation dated 09/05/18 indicated a total of 31 fire dampers were inspected and tested in the previous four year testing cycle for the facility's fire dampers. Based on interview at the time of record review, the Maintenance Director stated fire dampers have not been removed in the facility and agreed documentation of fire damper inspections conducted within the most recent four year period did not include all facility fire dampers. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)			
K 0754 SS=E Bldg. 01	NFPA 101 Soiled Linen and Trash Containers Soiled Linen and Trash Containers Soiled linen or trash collection receptacles shall not exceed 32 gallons in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gallons/square feet. A total container capacity of 32 gallons shall not be exceeded within any 64 square feet area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gallons shall be located in a room protected as a hazardous area when not attended. Containers used solely for recycling are permitted to be excluded from the above requirements where each container is less than or equal to 96 gallons unless attended, and containers for combustibles are labeled and listed as meeting FM Approval Standard 6921 or equivalent. 18.7.5.7, 19.7.5.7			

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	Based on observation and interview, the facility failed to ensure unattended soiled linen and trash receptacles in 1 of 8 means of egress were stored in a room protected as a hazardous area in accordance with 19.7.5.7. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of resident sleeping Room 505. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:45 p.m. to 2:20 p.m. on 05/24/23, one unattended partially filled soiled linen cart and one unattended partially filled trash cart were stored in the corridor next to one another outside resident sleeping Room 505. The lid for the partially filled trash cart stated the container capacity was 44 gallons and the partially filled soiled linen cart capacity was 32 gallons. Based on interview at the time of the observations, the Maintenance Director stated the facility keeps the two carts in the 500 Hall corridor and agreed the aforementioned soiled linen and trash carts were not being stored in a room protected as a hazardous area when unattended. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)	K 0754	**K-754- Soiled Linen Cart on Hall** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Soiled linen and trash receptacles were removed from the hallway. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. Residents in facility have the potential to be affected. Soiled linen and trash receptacles were removed from the hallway. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. Staff have been educated that soiled linen and trash receptacles should be stored in soiled utility room. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. Routine rounds will be conducted and include observation of hallways to ensure proper storage of soiled linen and trash receptacles. By what date the systemic changes for each deficiency will be completed? 6/8/2023	06/08/2023